Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAH Hines, IL - 578 and VA Chicago HCS (VAMC Chicago (LS) - 537A4 and VAMC Chicago (WS) - 537)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1030

2. Estimated Number of Veterans who are Chronically Homeless: 258

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1030 (estimated number of homeless veterans in service area) **x chronically homeless rate (25 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2212	0
Transitional Housing Beds	1094	236
Permanent Housing Beds	4309	413

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 30

3. CHALENG Point of Contact Action Plan for FY 2005

5	Partner with community agencies on grant submissions. Maintain VA representation on key community boards, task forces, coalitions. Continue partnership with Illinois Department of Veterans Affairs, VBA and Vet Centers in addressing need.
6	Partner with community agencies on grant submissions. Maintain VA representation on key community boards, task forces, coalitions. Continue partnership with Illinois Dept. of Veterans Affairs, VBA and Vet Centers in addressing need.
29	Improve networking by VA with Disabled Veterans Outreach programs, community employment resources and employers, and education and training resources.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **20** **Non-VA staff Participants: 60.0%**
Homeless/Formerly Homeless: **10.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.30	.0%	3.47
Food	3.60	5.0%	3.80
Clothing	3.50	5.0%	3.61
Emergency (immediate) shelter	2.60	42.0%	3.33
Halfway house or transitional living facility	2.35	26.0%	3.07
Long-term, permanent housing	2.11	68.0%	2.49
Detoxification from substances	3.20	.0%	3.41
Treatment for substance abuse	3.40	21.0%	3.55
Services for emotional or psychiatric problems	3.4	.0%	3.46
Treatment for dual diagnosis	3.5	11.0%	3.30
Family counseling	3.25	.0%	2.99
Medical services	3.90	.0%	3.78
Women's health care	3.30	11.0%	3.23
Help with medication	3.45	11.0%	3.46
Drop-in center or day program	2.65	.0%	2.98
AIDS/HIV testing/counseling	3.75	.0%	3.51
TB testing	3.70	.0%	3.71
TB treatment	3.45	.0%	3.57
Hepatitis C testing	3.85	.0%	3.63
Dental care	3.30	5.0%	2.59
Eye care	3.15	.0%	2.88
Glasses	3.00	.0%	2.88
VA disability/pension	3.35	5.0%	3.40
Welfare payments	2.90	5.0%	3.03
SSI/SSD process	2.85	5.0%	3.10
Guardianship (financial)	2.90	.0%	2.85
Help managing money	2.80	.0%	2.87
Job training	2.90	5.0%	3.02
Help with finding a job or getting employment	2.89	21.0%	3.14
Help getting needed documents or identification	3.37	.0%	3.28
Help with transportation	2.80	11.0%	3.02
Education	2.95	.0%	3.00
Child care	2.42	.0%	2.45
Legal assistance	2.37	5.0%	2.71
Discharge upgrade	2.75	5.0%	3.00
Spiritual	3.05	5.0%	3.36
Re-entry services for incarcerated veterans	2.15	21.0%	2.72
Elder Healthcare	3.00	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.25
Co-location of Services - Services from the VA and your agency provided in one location.	2.25
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.50
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.08
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.83
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.17
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.58
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.33
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.58
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.92
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.08

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.83
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.08

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAH Madison, WI - 607

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 176

2. Estimated Number of Veterans who are Chronically Homeless: 25

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 176 (estimated number of homeless veterans in service area) **x chronically homeless rate (14 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	297	0
Transitional Housing Beds	321	0
Permanent Housing Beds	413	165

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	The number one need for many years. 36 long-term beds are under construction but more are needed. I continue to work with the homeless coalition in Madison to identify veterans in need and place them when appropriate housing is available.
Transitional living facility or halfway house	We increased transitional housing by 33 beds this year. Talks have begun with Porchlight, Inc. for increasing beds through contract with VA Grant and Per Diem Program.
Job training	Staffing at the Madison Job Center has stabilized over past several months to include a permanent veterans representative. A strong relationship with the VA's CWT program continues to exist.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **26** **Non-VA staff Participants: 61.5%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.36	.0%	3.47
Food	3.62	.0%	3.80
Clothing	3.65	5.0%	3.61
Emergency (immediate) shelter	3.42	19.0%	3.33
Halfway house or transitional living facility	2.85	36.0%	3.07
Long-term, permanent housing	2.50	45.0%	2.49
Detoxification from substances	3.60	5.0%	3.41
Treatment for substance abuse	3.54	24.0%	3.55
Services for emotional or psychiatric problems	3.6	14.0%	3.46
Treatment for dual diagnosis	3.2	14.0%	3.30
Family counseling	3.04	.0%	2.99
Medical services	3.92	14.0%	3.78
Women's health care	3.23	.0%	3.23
Help with medication	3.29	.0%	3.46
Drop-in center or day program	3.00	10.0%	2.98
AIDS/HIV testing/counseling	3.48	.0%	3.51
TB testing	3.84	.0%	3.71
TB treatment	3.76	.0%	3.57
Hepatitis C testing	3.88	.0%	3.63
Dental care	2.32	14.0%	2.59
Eye care	2.92	.0%	2.88
Glasses	2.83	.0%	2.88
VA disability/pension	3.50	.0%	3.40
Welfare payments	2.57	5.0%	3.03
SSI/SSD process	3.08	10.0%	3.10
Guardianship (financial)	3.00	5.0%	2.85
Help managing money	2.81	10.0%	2.87
Job training	2.96	23.0%	3.02
Help with finding a job or getting employment	3.15	24.0%	3.14
Help getting needed documents or identification	3.29	.0%	3.28
Help with transportation	2.58	14.0%	3.02
Education	2.92	5.0%	3.00
Child care	2.17	.0%	2.45
Legal assistance	2.50	10.0%	2.71
Discharge upgrade	3.21	.0%	3.00
Spiritual	3.21	.0%	3.36
Re-entry services for incarcerated veterans	2.58	10.0%	2.72
Elder Healthcare	3.52	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.63
Co-location of Services - Services from the VA and your agency provided in one location.	2.13
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.94
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.81
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.88
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.81
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.13
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.63
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.69
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.81

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.94
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Iron Mountain, MI - 585

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 3

2. Estimated Number of Veterans who are Chronically Homeless: 1

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 3 (estimated number of homeless veterans in service area) **x chronically homeless rate (22 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	20	0
Transitional Housing Beds	15	10
Permanent Housing Beds	10	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Detoxification from substances	There is a need for immediate shelter for persons who are intoxicated. We will bring this up for discussion in coalition meetings and present this as a need for ongoing community planning.
Long-term, permanent housing	Continue to improve communication regarding services available, housing commission, housing assistance program, local landlords.
VA disability/pension	Continue to improve communications regarding services available. Develop a close working relationship with Veterans services and service officers.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **17** **Non-VA staff Participants: 64.7%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.40	.0%	3.47
Food	3.88	.0%	3.80
Clothing	3.94	.0%	3.61
Emergency (immediate) shelter	4.00	38.0%	3.33
Halfway house or transitional living facility	2.67	50.0%	3.07
Long-term, permanent housing	2.75	38.0%	2.49
Detoxification from substances	3.76	13.0%	3.41
Treatment for substance abuse	3.94	6.0%	3.55
Services for emotional or psychiatric problems	3.9	6.0%	3.46
Treatment for dual diagnosis	3.6	.0%	3.30
Family counseling	3.38	6.0%	2.99
Medical services	4.13	6.0%	3.78
Women's health care	3.88	.0%	3.23
Help with medication	3.71	.0%	3.46
Drop-in center or day program	2.63	6.0%	2.98
AIDS/HIV testing/counseling	3.47	.0%	3.51
TB testing	3.87	.0%	3.71
TB treatment	3.53	.0%	3.57
Hepatitis C testing	3.87	.0%	3.63
Dental care	2.06	44.0%	2.59
Eye care	2.25	6.0%	2.88
Glasses	2.38	.0%	2.88
VA disability/pension	3.94	.0%	3.40
Welfare payments	3.38	.0%	3.03
SSI/SSD process	3.40	.0%	3.10
Guardianship (financial)	2.67	6.0%	2.85
Help managing money	2.69	13.0%	2.87
Job training	2.75	6.0%	3.02
Help with finding a job or getting employment	2.94	13.0%	3.14
Help getting needed documents or identification	3.07	.0%	3.28
Help with transportation	2.53	13.0%	3.02
Education	3.00	.0%	3.00
Child care	2.82	.0%	2.45
Legal assistance	2.50	13.0%	2.71
Discharge upgrade	2.94	.0%	3.00
Spiritual	3.53	.0%	3.36
Re-entry services for incarcerated veterans	2.63	13.0%	2.72
Elder Healthcare	3.27	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.67
Co-location of Services - Services from the VA and your agency provided in one location.	1.63
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.89
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.56
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.67
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.56
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.67
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.33
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.56
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.33

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.73
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.64

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Milwaukee, WI - 695

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 189

2. Estimated Number of Veterans who are Chronically Homeless: 59

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 189 (estimated number of homeless veterans in service area) **x chronically homeless rate (31 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	726	0
Transitional Housing Beds	385	0
Permanent Housing Beds	618	56

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Strengthen and develop new relationships with continuing care permanent supportive housing providers to increase options for permanent housing.
Help finding a job or getting employment	Increase referrals to CWT and Supported Employment Programs.
Transitional living facility or halfway house	Promote VA Grant and Per Diem program as a potential resource for homeless providers.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **54** **Non-VA staff Participants: 94.3%**
Homeless/Formerly Homeless: **5.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.19	2.0%	3.47
Food	3.66	13.0%	3.80
Clothing	3.66	.0%	3.61
Emergency (immediate) shelter	3.16	34.0%	3.33
Halfway house or transitional living facility	2.98	28.0%	3.07
Long-term, permanent housing	2.42	54.0%	2.49
Detoxification from substances	2.98	11.0%	3.41
Treatment for substance abuse	2.90	17.0%	3.55
Services for emotional or psychiatric problems	2.9	17.0%	3.46
Treatment for dual diagnosis	2.6	15.0%	3.30
Family counseling	2.81	2.0%	2.99
Medical services	3.52	4.0%	3.78
Women's health care	2.89	6.0%	3.23
Help with medication	2.91	.0%	3.46
Drop-in center or day program	2.98	9.0%	2.98
AIDS/HIV testing/counseling	3.28	.0%	3.51
TB testing	3.34	.0%	3.71
TB treatment	3.24	.0%	3.57
Hepatitis C testing	3.21	.0%	3.63
Dental care	2.65	4.0%	2.59
Eye care	2.94	.0%	2.88
Glasses	2.89	.0%	2.88
VA disability/pension	3.46	4.0%	3.40
Welfare payments	2.85	2.0%	3.03
SSI/SSD process	3.02	.0%	3.10
Guardianship (financial)	2.94	.0%	2.85
Help managing money	2.91	4.0%	2.87
Job training	3.11	9.0%	3.02
Help with finding a job or getting employment	3.23	33.0%	3.14
Help getting needed documents or identification	3.21	.0%	3.28
Help with transportation	2.69	4.0%	3.02
Education	3.06	4.0%	3.00
Child care	2.56	2.0%	2.45
Legal assistance	3.04	.0%	2.71
Discharge upgrade	3.20	2.0%	3.00
Spiritual	3.17	2.0%	3.36
Re-entry services for incarcerated veterans	2.52	13.0%	2.72
Elder Healthcare	2.85	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.25
Co-location of Services - Services from the VA and your agency provided in one location.	1.65
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.75
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.08
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.56
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.77
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.90
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.83
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.45
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.64
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.65

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.42
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.32

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC North Chicago, IL - 556

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 238

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 238 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	112	25
Transitional Housing Beds	154	0
Permanent Housing Beds	236	79

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Our new 15-unit Shelter Plus Care program will continue admitting chronically homeless. We will consider additional funding for expansion. Will outreach to community groups and local government to provide additional, affordable housing.
Immediate shelter	Encourage P.A.D.S. to provide additional sites, especially year-round sites. Also disseminate information about rent assistance available from Lake and McHenry County Veterans Assistance Commissions.
Re-entry services for incarcerated veterans	Members of Lake County Coalition for Homeless have already met with Sheriff/Department of Corrections and assisted them with developing a discharge planner position for the jail. We anticipate continuing to network and to assist this discharge planner.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **23** **Non-VA staff Participants: 95.7%**
Homeless/Formerly Homeless: **8.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.62	.0%	3.47
Food	3.59	25.0%	3.80
Clothing	3.43	5.0%	3.61
Emergency (immediate) shelter	3.45	35.0%	3.33
Halfway house or transitional living facility	3.38	20.0%	3.07
Long-term, permanent housing	2.38	48.0%	2.49
Detoxification from substances	3.95	5.0%	3.41
Treatment for substance abuse	3.77	10.0%	3.55
Services for emotional or psychiatric problems	4.1	10.0%	3.46
Treatment for dual diagnosis	3.9	.0%	3.30
Family counseling	3.33	.0%	2.99
Medical services	4.25	.0%	3.78
Women's health care	3.53	10.0%	3.23
Help with medication	3.75	.0%	3.46
Drop-in center or day program	3.20	5.0%	2.98
AIDS/HIV testing/counseling	3.58	.0%	3.51
TB testing	3.74	.0%	3.71
TB treatment	3.72	.0%	3.57
Hepatitis C testing	3.71	.0%	3.63
Dental care	3.00	10.0%	2.59
Eye care	3.11	.0%	2.88
Glasses	2.89	.0%	2.88
VA disability/pension	3.50	.0%	3.40
Welfare payments	3.63	5.0%	3.03
SSI/SSD process	3.61	10.0%	3.10
Guardianship (financial)	3.35	.0%	2.85
Help managing money	3.35	5.0%	2.87
Job training	2.79	20.0%	3.02
Help with finding a job or getting employment	2.95	14.0%	3.14
Help getting needed documents or identification	3.35	.0%	3.28
Help with transportation	2.78	25.0%	3.02
Education	3.00	.0%	3.00
Child care	2.61	.0%	2.45
Legal assistance	3.21	.0%	2.71
Discharge upgrade	3.06	5.0%	3.00
Spiritual	3.47	5.0%	3.36
Re-entry services for incarcerated veterans	2.83	30.0%	2.72
Elder Healthcare	3.12	5.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.57
Co-location of Services - Services from the VA and your agency provided in one location.	1.82
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.38
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.95
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.41
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.27
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.43
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.77
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.76
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.24
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.24
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.48

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.70

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Tomah, WI - 676

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 550

2. Estimated Number of Veterans who are Chronically Homeless: 61

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 550 (estimated number of homeless veterans in service area) **x chronically homeless rate (11 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	50
Transitional Housing Beds	164	75
Permanent Housing Beds	125	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Work more closely with Wisconsin Bureau of Housing and internet resources to find housing in surrounding area versus just working with "usual landlords. Collaborate with local housing authorities to develop informal agreements.
Dental care	Educate local service agencies and VA providers/staff on Wisconsin Health Care Aid grants for Wisconsin veterans as well as one-time treatment option for homeless program residents. Encourage dental applications.
Immediate shelter	Develop tracking system of veterans referred to shelter for immediate need. Gather statistics to justify need. Utilize donations for hotel voucher for immediate shelter (closest shelter is 45 miles). Utilize on-station lodging in crisis situations.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **57 Non-VA staff Participants: 96.5%**
Homeless/Formerly Homeless: **68.4%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	4.30	2.0%	3.47
Food	4.46	2.0%	3.80
Clothing	4.05	4.0%	3.61
Emergency (immediate) shelter	3.81	25.0%	3.33
Halfway house or transitional living facility	3.74	18.0%	3.07
Long-term, permanent housing	3.18	46.0%	2.49
Detoxification from substances	4.09	.0%	3.41
Treatment for substance abuse	4.35	9.0%	3.55
Services for emotional or psychiatric problems	4.2	9.0%	3.46
Treatment for dual diagnosis	4.1	4.0%	3.30
Family counseling	3.24	4.0%	2.99
Medical services	4.18	12.0%	3.78
Women's health care	3.73	4.0%	3.23
Help with medication	4.18	.0%	3.46
Drop-in center or day program	3.26	.0%	2.98
AIDS/HIV testing/counseling	3.73	.0%	3.51
TB testing	4.54	.0%	3.71
TB treatment	4.04	.0%	3.57
Hepatitis C testing	4.32	2.0%	3.63
Dental care	3.07	28.0%	2.59
Eye care	3.49	4.0%	2.88
Glasses	3.51	5.0%	2.88
VA disability/pension	3.63	16.0%	3.40
Welfare payments	2.74	2.0%	3.03
SSI/SSD process	3.06	5.0%	3.10
Guardianship (financial)	3.07	5.0%	2.85
Help managing money	3.44	4.0%	2.87
Job training	3.43	18.0%	3.02
Help with finding a job or getting employment	3.56	23.0%	3.14
Help getting needed documents or identification	3.98	4.0%	3.28
Help with transportation	3.67	14.0%	3.02
Education	3.67	12.0%	3.00
Child care	2.72	.0%	2.45
Legal assistance	3.00	9.0%	2.71
Discharge upgrade	3.11	5.0%	3.00
Spiritual	3.70	2.0%	3.36
Re-entry services for incarcerated veterans	2.82	7.0%	2.72
Elder Healthcare	3.34	2.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.71
Co-location of Services - Services from the VA and your agency provided in one location.	2.76
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.38
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.75
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.49
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.24
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.49
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.45
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.42
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.27
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.25
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.37

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.47
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.65